Psychiatric Residential Treatment
Questions from 2007 Training

1. **Is notification for injury reporting a provider requirement? Does the provider need to notify DMAS of the outcome of the treatment for the injury?**

It is a provider requirement to notify DMAS of serious incidents, which include a resident's death, suicide attempt, or a serious injury which requires medical attention. This must be done within one business day of the incident. This is one of the restraint & seclusion regulations which must be adhered to, and is a condition of continued participation as a Medicaid provider. See the Psychiatric Services Manual, Chapter II, pages 5-7.

If the outcome of the incident is available at the time of the report, the outcome would be part of the report.

2. **Does the agency have to remember to update CEO changes or does DMAS send out some reminder?**

It is the provider's responsibility to notify DMAS of any changes in CEOs. At enrollment and annually thereafter, no later than July 1, the provider must submit a new attestation to DMAS. See the Psychiatric Services Manual, Chapter II, page 5.

3. **Who determines the non-CSA rate?**

The non-CSA rate is established at the time a provider first enrolls with Medicaid. The rate is based on financial information sent in to Medicaid related to the provider's cost of doing business.

4. **Is an Adoption Subsidy case a CSA or non-CSA case?**

Non-CSA. No Reimbursement Rate Certification is required.

5. **Why does KePRO need the name of the locality?**

KePRO will take the locality code submitted by the provider and send it to the DMAS fiscal agent, First Health Services. The locality designated by the provider is considered fiscally responsible for the child. If the incorrect locality code is provided to KePRO, it must be corrected, since this will have some financial impact on the designated locality. The locality code is only required on CSA cases.

6. **Can you explain adoption subsidy placements and CSA funding for education?**

Based on the Office of Comprehensive Services broadcast dated March 13, 2002, DMAS considers an adoption subsidy placement a NON-CSA placement, no matter the source of funding for education.

7. **How do you handle an adoption subsidy when one locality has the adoption subsidy but another locality provides the educational services?**

Adoption subsidy cases are non-CSA cases. It does not matter who pays for the education. On the KePRO PA fax form the provider must check Adoption Subsidy for item number 20.

8. **Are there requirements for screeners?**

The screener for the non-CSA certificate of need (CON) is the CSB screener. The requirements for qualifications of screeners would be up to the CSB. The CON or DMAS 224 must also include a dated signature of a physician.

9. **If a child is screened by the CSB for residential, and the CSB does not find it the correct level of care, can the FAPT decide to place the child in residential?**

A child should be screened by the CSB if they are a non-CSA child. A physician and the CSB screener must sign the Certificate of Need. A child should be screened by the FAPT if they are a CSA child, or if they are Adoption Subsidy. At least three members of the

FAPT and a physician must sign the Certificate of Need. There should not be a duplication of screenings.

10. If the FAPT does not approve placement, can the parent take the child to the CSB for screening? Is it ok if the parents take the child to their family physician for a certificate of need for placement?

No and no. See the answer above.

11. If a child goes into acute care services, do you need to have all the original FAPT signatures on the assessment?

No, when a child is coming to an RTF from acute care, the acute care facility must complete the CON. It must include the dated signature of the MD and another member of the acute care treatment team.

12. What is required to document that you provided supervision?

If a non-licensed therapist provides therapy and is under the direct, personal supervision of a licensed therapist who is a Medicaid provider, the supervisor must add a dated signature to the note on the date of the session, indicating review of the note. The supervisor must be in the facility during the session, and must meet regularly with the supervisee, meeting to discuss the patient's progress and plan of care at least every 6th therapy session (including individual, family and group psychotherapy).

13. What do you do with family therapy, when the family chooses not to participate?

If the plan is for the child to return to the family at some point, not necessarily directly from the residential stay, family therapy should occur weekly. This is the opportunity to provide an intensive level of services. If any part of the reason for admission is due to family issues, family therapy should occur weekly. If a family member is communicating with the child, and this is negatively impacting treatment, family therapy with this member should be occurring. If family therapy is part of the treatment plan and family is unwilling to cooperate, this must be addressed. If the family's lack of cooperation with a treatment plan is negatively impacting the child, and prolonging treatment, this must be addressed. It may mean the discharge plan is changed, or it may take the intervention of the placing agency, but it should not be allowed to continue and prolong the residential stay.

If the family can only come on weekends or in the evening, the provider must accommodate this schedule. Telephonic therapy can take the place of some of the required sessions, but at least one face-to-face session must take place monthly when there is family involvement. Telephonic therapy is not billable.

14. Can someone else sign the CON for the CMPT coordinator, if they are not available?

There is no requirement for the CPMT coordinator to sign the CON. The CON must be signed by, at a minimum, three FAPT members and a physician.

The rate reimbursement certification must be signed by the CPMT chair, but if that person is not available, and if the locality allows, someone could sign for the CPMT chair, and this should be indicated at the place of signature.

15. Can one of the 21 therapeutic interventions be when a staff member sees a child in the halls and stops the child to talk to them?

No, this would be part of the daily supervision that is part of the per diem reimbursement. The 21 therapeutic interventions are required to be planned interventions and addressed in the treatment plan.

16. Is there a time requirement for the 21 treatment interventions?

The requirement is for 21 treatment interventions per week. There is no specified length of time for an intervention. It must be planned, and therapeutic in nature, and be child-specific, addressing each child's individual needs.

17. Are there any facilities that accept sex offender children?

Yes, there are a number of facilities that accept children with varying types of problems. If you have a child-specific placement need and cannot find an appropriate placement, you can contact DMAS for additional contact information on Virginia providers. DMAS contact information is on slide 2 of the 2007 Residential Treatment training.

18. Can you explain the difference between transfer to acute medical for less than 7 days and transfer to acute psychiatric for less than 7 days?

Transfer for medical treatment is not a change in the level of care for the mental health problem treated at the residential program. Transfer for acute psychiatric treatment is a change in level of care. If a child transfers from residential to acute medical care, and the stay is for 7 days or less, the transfer does not need to be treated as a discharge for Medicaid purposes. The days the child is in the acute care hospital, the residential stay should not be billed. If a child transfers from residential to acute psychiatric care, the child should be considered discharged from residential for Medicaid purposes.

19. Can reimbursement be made to more than one facility per month?

If a child is discharged from one facility and moves to another, payment can be made to both facilities in the same month. Payment is on a per diem basis. Each facility would only bill the dates of service the child resided with them. Each facility would not bill the date of discharge.

20. If the 3 individual therapy sessions in 7 days is not completed, will the facility's payment be retracted?

The requirement is for 3 individual therapy sessions every 7 days. If a session is missed every once in awhile due to exceptional circumstances, and these are clearly documented, retraction is unlikely. The expectation is if a child is unable to attend due to going on an overnight visit, the session that was scheduled during that time would be made up during the 7 day period. The same applies if a therapist is out on vacation or out due to illness, the expectation is the facility will have coverage to ensure the DMAS criteria are met. Residential treatment is expected to be a 24-hour-a-day, intensive therapeutic program.

21. How many patients can be in a group session?

Group psychotherapy can have no more than 10 participants. Groups that are not psychotherapy, but will count towards the 21 treatment interventions required each week, can include more, as long as the group leader can manage the group, and it remains therapeutic. Group psychotherapy is billable separately by a licensed therapist who is a Medicaid provider. Therapeutic group interventions provided by unlicensed individuals are not billable.

22. How is the 7-day period established to count the number of sessions?

It is up to the facility to determine the 7-day period they use to track service requirements. The 7-day period could be from Sunday through Saturday, or Monday through Sunday, or from admission to discharge. The auditors will ask the facility how they track the sessions required.

23. What is the turn around time for processing PA requests?

The turnaround time for a "clean" request, meaning all required information is submitted to KePRO, is three days.

24. What criteria are used for an initial review?

KePRO applies both InterQual® Behavioral Health Criteria and DMAS criteria described in the Psychiatric Services Manual. The information required for KePRO review submission should come from documentation in the medical record. Only DMAS criteria are applied to subsequent reviews.

25. What is the difference between the CIPOC and the 30-day update required for submission to KePRO?

The CIPOC is the Comprehensive Individual Plan of Care, required to be completed within 14 days of admission. The CIPOC is required to be updated every 30 days thereafter. The update can be a complete re-do of the CIPOC, incorporating any changes to the plan, and documentation of progress made, or it could be a separate document that indicates the changes to the CIPOC. It is up to the facility how they will document the updates. There is a sample CIPOC and CIPOC 30-Day Progress Update in the Psychiatric Services Manual, Chapter IV, in the Exhibits section. The format for the documents is up to the facility, but all the required elements are noted on the sample forms.

26. Does a physician need to see the new resident within a particular period of time? What if the resident is admitted on a Friday?

The Initial Plan of Care must be developed within 24 hours of admission. The physician must sign the IPC within 24 hours of admission, and this is to indicate the physician has made a face-to-face evaluation of the new resident, and established a resident-specific initial plan of care. If the resident is admitted on Friday at 4:00 p.m., by Saturday at 4:00 p.m. the IPC must be complete, including the physician's dated signature and available for review in the medical record. The RTF program is expected to be an intensive, 24-hour-a-day, therapeutic program to address severely emotionally and behaviorally disturbed children.

For questions about DMAS psychiatric residential treatment program criteria, contact Shelley Jones at shelley.jones@dmas.virginia.gov

For questions about the prior authorization process, contact KePRO at 1888-627-2864 or by e-mail at ProviderIssues@kepro.org.

For on-going provider issues, contact DMAS at PAUR06@DMAS.virginia.gov.